Research Brief:

Racial and Ethnic Disparities in the Experiences of Health Care Consumers

I. Introduction

In 2003, the federal Agency for Healthcare Research and Quality (AHRQ) released the nation's first annual report that tracked prevailing disparities in health care delivery as they relate to racial and socioeconomic factors in priority populations.[1] The report stated that closing the health gap for minorities and other priority populations is a major objective of the United States Department of Health and Human Services.

The *2004 National Healthcare Disparities Report* defines disparities broadly as any differences among populations in measures of health and health care.[2] Health disparities can result from a variety of causes, including differences in the needs, expectations, preferences, or health status of patients, uneven availability of care, or differential treatment by providers.

The 2004 report highlighted three key themes about health care disparities:

1. Disparities are pervasive across health care dimensions, settings and subpopulations.
2. Improvement (eliminating or decreasing disparities) is possible.
3. Gaps in information exist, especially for specific conditions and populations.

In recent years, several studies have examined disparities in consumer and patient experiences with health care. This brief highlights research on racial and ethnic differences in consumer perceptions of care as measured by the CAHPS® Health Plan Survey. This document is the second release in an occasional series of findings from research conducted using data from the National CAHPS Benchmarking Database.[3]

CAHPS Surveys and the National CAHPS Benchmarking Database

In 1995, AHRQ initiated the CAHPS program to develop surveys that venture beyond the measurement of patient satisfaction to elicit *reports* from health plan enrollees about their experiences with care. Over the past several years, CAHPS has evolved from the health plan survey into a broader set of survey instruments and reports designed to measure and communicate information on patients' experiences with various aspects of the health care system, including hospitals, medical groups, clinicians, nursing homes, and dialysis facilities.

Overview of the CAHPS Health Plan Survey

The CAHPS Health Plan Survey includes instruments for adults as well as the parents or guardians of children 17 and younger. These instruments can be used across different types of health insurance enrollees (commercial, Medicaid, and Medicare) and the full range of health care delivery systems, from fee-for-service to managed care plans. Health plans and other sponsors often add supplemental questions to these instruments to meet other information needs (e.g., to collect data on the experiences of adults

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1 National Healthcare Disparities Report, December 2003. Agency for Healthcare Research and Quality, Rockville, MD.

2 2004 National Healthcare Disparities Report, December 2004. Agency for Healthcare Research and Quality, Rockville, MD.

3 The first release, "Quality of Care for Children with Special Health Care Needs," was published in February 2004 and is available at: http://ncbd.cahps.org/NCBDNews/cshcn_fact_sheet.pdf.

AHRQ Agency for Healthcare Research and Quality
Advancing Excellence in Health Care www.ahrq.gov

II. What Do CAHPS Data Reveal About Racial and Ethnic Disparities in Consumer Experience?

The purpose of this research brief is to summarize findings from studies that analyzed data from the CAHPS Database to assess racial and ethnic differences in the experiences of health plan enrollees. This section presents the key findings across these studies as well as item-level findings from studies that include composite- and rating-specific comparisons by race and ethnicity.

Key Findings Across the Studies

Three key findings emerged from our review of studies:

- Most studies found evidence of health disparities with racial and ethnic minorities reporting worse care than whites. Interestingly, there are smaller racial and ethnic disparities in ratings of care than in reports of experiences with care.
- Non-English speakers tended to report worse care than both whites and racial and ethnic minorities.
- Asians, especially those who do not speak English, have the most negative perceptions of care.

CAHPS Surveys and the National CAHPS Benchmarking Database, continued from page 1

receiving behavioral health services) or to comply with the National Committee for Quality Assurance's (NCQA) requirements for HEDIS (the Health Plan and Employer Data and Information Set) and accreditation. The CAHPS Health Plan Survey has been translated and validated in Spanish; additional translations are available in other languages including Vietnamese, Mandarin, Cambodian, Korean, and Arabic.

Measures Generated by the CAHPS Health Plan Survey

To facilitate the reporting of results, CAHPS Health Plan Survey questions are organized into composites and ratings. As displayed below, the composites summarize enrollees' experiences with care across five domains while the ratings represent respondents' assessments of their providers, health plan, and overall health care.

Composites	Ratings of Care
Getting Needed Care	Personal Doctor or Nurse
Getting Care Quickly	Specialist Seen Most Often
How Well Doctors Communicate	All Health Care
Courteous and Helpful Office Staff	Health Plan
Customer Service	

The National CAHPS Benchmarking Database

The National CAHPS Benchmarking Database (the CAHPS Database) is the national repository for data from the CAHPS family of surveys. It contains current and historical CAHPS Health Plan Survey data for commercial (employer-sponsored), Medicaid, State Children's Health Insurance Program (SCHIP), and Medicare health plans. Participation in the CAHPS Database is open to all sponsors that administer the surveys according to the CAHPS Database specifications.

The CAHPS Database is an important resource for survey sponsors, researchers, and others interested in using comparative CAHPS survey results and detailed benchmark data. It allows participating sponsors to compare their results with those of other public and private sponsors. Sponsors can also use the benchmarks derived from the data to evaluate and set objectives for performance improvements.

Findings by Racial or Ethnic Category

Symbols

Throughout this section the following symbols are used to summarize the findings across the five studies reviewed that included direct comparisons by racial or ethnic category. Each racial or ethnic category is compared to white or white English speakers.

⊕ = A majority of studies indicate a more positive result than the comparison group.

○ = Results are mixed or there is no strong indication of a difference from the comparison group.

⊖ = A majority of studies indicate a more negative result than the comparison group.

Table 1: Blacks Compared to Whites

	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Courteous and Helpful Office Staff	Customer Service	Rating of the Doctor/ Nurse	Rating of Specialist	Rating of All Health Care	Rating of Health Plan
Blacks	○	⊖	⊕	○	⊕	⊕	○	○	⊕

Findings for blacks are mixed across the studies reviewed, with blacks reporting both better and worse experiences with care than whites. Across the studies reviewed, blacks consistently report better experiences with provider communication and customer service and better ratings of personal doctor/nurse and the health plan.[2,3,4,6]

In contrast, blacks consistently report worse experiences with getting care quickly.[4,5,6] The studies found no difference or mixed results for getting needed care, courteous and helpful office staff, rating of specialist, and rating of all health care.

Table 2: Hispanics/Latinos Compared to Whites

	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Courteous and Helpful Office Staff	Customer Service	Rating of the Doctor/ Nurse	Rating of Specialist	Rating of All Health Care	Rating of Health Plan
Hispanics/ Latinos (2 studies)	○	○	○	○	○	○	○	○	⊕
Hispanic English speaker (3 studies)	○	⊖	○	⊖	⊕	○	○	○	⊕
Hispanic Spanish speaker (3 studies)	○	⊖	⊖	⊖	○	⊕	⊕	⊕	⊕

All five studies included comparisons of Hispanics/Latinos to whites, but three of the five studies also subdivided Hispanics/Latinos by language spoken. Therefore, two of the studies compared Hispanics/Latinos to whites while three of the studies compared Hispanic/Latino English and Spanish speakers to white English speakers. In general, Hispanics/Latinos reported similar or worse experiences with care but had similar or higher ratings of care than whites or white English speakers.[2,3]

Again, language appears to have a strong effect on the results. For composites, Hispanics/Latinos as a group reported similar experiences to whites. However, when subdivided by language, they gave consistently lower reports for getting care quickly and courteous and helpful office staff.[4,5,6] For ratings, Hispanics/Latinos gave more positive ratings of the health plan and Hispanic/Latino Spanish speakers provided more positive ratings in all areas.[4,5,6]

Table 3: Asians/Pacific Islanders Compared to Whites

	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Courteous and Helpful Office Staff	Customer Service	Rating of the Doctor/ Nurse	Rating of Specialist	Rating of All Health Care	Rating of Health Plan
Asians (2 studies)	⊖	⊖	⊖	○	○	○	○	○	○
Asian English speaker (3 studies)	○	○	○	○	⊕	⊕	○	⊕	⊕
Asian other language (3 studies)	⊖	⊖	⊖	⊖	○	⊖	⊖	⊖	⊖

All five studies included comparisons of Asians to whites, but as with Hispanics/Latinos, three out of the five studies subdivided Asians by language spoken. Therefore, two of the studies compared Asians to whites while three of the studies compared Asian English speakers and Asian speakers of other languages to white English speakers. Overall, Asians/Pacific Islanders report experiences of care that tend to be worse than whites. For composites, Asians/Pacific Islanders report worse experiences for getting needed care, getting care quickly, and doctor communication.[2,3] The ratings of Asians/Pacific Islanders are lower or comparable, except for the rating of the health plan, for which they report comparable or higher ratings.[2,3] When categorized by language, Asian English speakers provided similar reports of care while Asian non-English speakers provided worse reports of care – in fact, the lowest reports of all racial/ethnic subgroups.[4,5,6] As a group, Asians had ratings of care similar to that of whites, but the language effect remains apparent with Asian English speakers having comparable or more positive ratings while Asian non-English speakers reported more negative ratings than white English speakers.[4,5,6]

Table 4: American Indians/Native Alaskans Compared to White

	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Courteous and Helpful Office Staff	Customer Service	Rating of the Doctor/ Nurse	Rating of Specialist	Rating of All Health Care	Rating of Health Plan
American Indians/ Native Alaskans (4 studies)	⊖	⊖	○	⊖	○	○	○	⊖	○

Four studies included American Indians/Native Alaskans. Overall, American Indians/Native Alaskans reported similar or worse experiences with care and gave similar or worse ratings than whites. For composites, American Indians/Native Alaskans reported worse experiences with getting needed care, getting care quickly, and courteous and helpful office staff.[4,5,6] American Indians/Native Alaskans gave similar ratings of care except for the rating of all health care, which was lower than whites.[5,6]

Sources

For the Research Brief, the authors reviewed published literature on racial and ethnic differences found in CAHPS Health Plan Survey results. The research studies listed below were published between 2001 and 2005 and included a variety of institutions such as Harvard Medical School, RAND, University of California Los Angeles, AHRQ, and the Centers for Medicare and Medicaid Services. The specific findings presented in the tables are based on results from studies 2-6, all of which included composite- and rating-level comparisons by race or ethnicity. The findings are referenced back to these study numbers.

Referenced Articles:

1. Kim M, Zaslavsky AM, & Cleary P. Adjusting pediatric consumer assessment of health plans study (CAHPS) scores to ensure fair comparison of health plan performances. *Medical Care*, January 2005. 43(1), 44-52.

2. Lurie N, Zhan C, Sangl J, Bierman A, and Sekscenski E. Variation in racial and ethnic differences in consumer assessments of health care. *The American Journal of Managed Care*, July 2003. 502-509.

3. Morales LS, Elliott MN, Weech-Maldonado R, Spritzer KL, Hays RD. Differences in CAHPS adult survey reports and ratings by race and ethnicity: an analysis of the National CAHPS Benchmarking Data 1.0. Health Serv Res. 2001 Jul;36(3):595-617.

4. Weech-Maldonado R, Elliott M, Morales LS, Spritzer K, Marshall G, & Hays RD. Health plan effects on patient assessments of Medicaid managed care among racial/ethnic minorities. *Journal of General Internal Medicine*. 2004 19, 136-145.

5. Weech-Maldonado R, Morales LS, Spritzer K, Elliott M, & Hays RD. Racial and ethnic differences in parents' assessments of pediatric care in Medicaid managed care. *Health Services Research*, 2001. 36, 575-594.

6. Weech-Maldonado R, Morales LS, Elliott M, Spritzer K, Marshall G, & Hays RD. Race/ethnicity, language and patients' assessments of care in Medicaid managed care. *Health Services Research*, 2003. 38, 789-80

Methods: Assignment to Racial or Ethnic Categories

The researchers assigned respondents to racial and ethnic categories according to their responses to two questions from the CAHPS Health Plan Survey. Anyone who indicated they were of Hispanic or Latino descent was put in that category regardless of race indicated. The respondents who indicated they were not of Hispanic or Latino descent were assigned to the indicated racial category. The table below illustrates the racial and ethnic assignments.

Some studies also included multiracial categories, but those results are not presented in this document. Some studies examined results for primary language (English versus other) by race and ethnicity. All of the studies compare the responses from the non-white racial and ethnic categories to responses from white respondents. None of the studies included statistical comparisons between other racial and ethnic categories (e.g., Asians to Hispanics).

1. Are you of Hispanic or Latino origin or descent?	2. What is your race?	Racial/Ethnic Category Assignment
Yes	Any	Hispanic/Latino
No	White	White
No	Black/ African American	Black
No	Asian/Pacific Islander	Asian/Pacific Islander
No	American Indian/ Alaskan Native	American Indian/ Alaskan Native

III. What are the Implications of the Findings?

The consistent finding of disparities in consumer experiences of care by race and ethnicity points to the need for both further information and strategies to address the gaps.

Opportunities for Addressing Disparities

As discussed in this document, the research conducted to date on the CAHPS Health Plan Survey data clearly demonstrates that the reports and ratings of care of health plan members who are racial or ethnic minorities are different than those of white members. The same findings hold true for non-English speaking health plan members. While further research is required to understand why racial, ethnic, and linguistic minorities report worse experiences with care, health plans can take action to reduce the disparities by improving the care and services provided to these populations. These opportunities include the following strategies:

- **Identify disparities within their plan populations** – Identifying racial/ethnic or linguistic disparities within their populations would allow plans to devise different strategies for meeting the needs of the respective groups. For example, stratifying data by race or ethnicity may indicate that a plan's low result on "how well doctors communicate" may be primarily due to low ratings from a large population of Asian members. This knowledge would allow the plan to devise specific strategies targeting that population and their providers, thereby improving care for members more efficiently.

- **Stratify ongoing quality improvement activities by race, ethnicity or language spoken where appropriate** – Health plans conduct a variety of ongoing quality improvement activities that may benefit from additional stratification. For example, a plan may find that Hispanic Spanish-speaking members report poor experiences with "getting care quickly" primarily because when they call for an appointment, the clinic does not have a staff person who speaks Spanish but instead has to arrange for an interpreter. This finding could lead the health plan to broaden its network to include Spanish-speaking providers or staff where appropriate. Re-examining ongoing efforts stratified by race or ethnicity could yield important and actionable information that the health plan may not otherwise detect.

- **Tailor health education and outreach efforts by race, ethnicity or language spoken** – Acknowledging differences among members allows the health plan to more effectively target quality improvement outreach to racial, ethnic, or linguistic groups that are experiencing negative disparities. For example, a health plan may have a low result for "rating of personal doctor" specifically for American Indian members. Further investigation may reveal a lack of understanding of plan procedures for selecting a personal doctor or the role of the personal doctor. These findings would allow the plan to target educational and outreach efforts to this particular population and the providers that serve them with the goal of improving the doctor-patient relationship and thereby improving the enrollees' rating of their personal doctor.

To learn more about . . .

The survey . . . see the CAHPS User Network Web site **(http://www.cahps-sun.org)**

CAHPS data and results . . . see the National CAHPS Benchmarking Database Web site **(http://ncbd.cahps.org/Home/index.asp)**

Using CAHPS for quality improvement . . . see *The CAHPS Improvement Guide* **(http://www.cahps-sun.org/References/CAHPSImprovementGuide.asp)**

Questions to Explore

The studies reviewed had many significant findings that point to areas where further research would be helpful. Questions in need of further research include:

- **Why aren't the reports and ratings for the same subgroup consistent?**

  CAHPS surveys were designed to include consumer *reports* and ratings of care. Consumer reports on experiences of care are intended to more directly reflect the quality of care while consumer *ratings* provide an evaluation of care; therefore expectations may play a greater role in ratings than reports. Research has demonstrated that even when racial/ethnic groups report worse experiences with care, their ratings of care are often more similar to that of whites. Are the differences between CAHPS reports and ratings the result of different respondent expectations? For example, do Asians have an expectation of worse experience that leads them to rate care more favorably than their reports of care would indicate?

- **What are the determinants of the negative health care experiences among Asians/Pacific Islanders?**

  Asians consistently report the worst experiences of all racial and ethnic groups. What accounts for this finding? Is it related to differences in Western and Eastern approaches to health care and medicine? What other cultural factors may be involved?

- **Do CAHPS surveys accurately capture differences in language, ethnicity, race, and culture?**

  One study to date revealed that the majority of observed racial and ethnic differences in CAHPS reports and ratings of care are attributable to within-plan effects (rather than between-plan effects.)[4] Is the CAHPS instrument accurately identifying distinct racial, ethnic and language subgroups or are the differences within these groups larger than the differences among them?

Products of the National CAHPS Benchmarking Database

The CAHPS Database currently offers several products and services to facilitate benchmarking and research based on CAHPS Health Plan Survey results:

- **Sponsor Reports** – Each fall, participating commercial and Medicaid sponsors receive a free, customized report comparing their results to appropriate benchmarks including national and regional distributions. Sponsor reports are currently generated electronically as PDF files, but future plans include an interactive electronic format that will allow sponsors to manipulate their reports and create custom tables through secure Internet portals.

- **Annual Chartbook** – This report, which is published each fall, presents cross-sector comparisons of CAHPS Health Plan Survey results for commercial (adult and child), Medicaid (adult and child), SCHIP (child), and Medicare (adult) populations. These results are based on the current year's data, and include data from the prior year as well. Sponsors and others can compare these national distributions to their own survey results in order to assess plan performance and identify opportunities for improvement.

- **Custom Analyses and Reports** – Staff of the CAHPS Database are available to conduct specialized data analyses and reports upon request. All analyses and reports adhere to CAHPS Database policies regarding confidentiality of respondents, plans, and sponsors.

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- **Are the observed differences due to lack of measurement equivalence (differential response tendencies) or real differences in care received?**

  The research has demonstrated that racial/ethnic groups report on and rate their care differently, but is this finding due to real differences in care or different ways of responding to survey response choices? In other words, do blacks tend to give higher ratings than other racial or ethnic groups because they receive better care or because they use the response scale differently (i.e., tend to use higher or lower ratings more often than respondents of other racial or ethnic groups)?

- **Are health plans that serve a disproportionate share of population groups that tend to give lower scores unfairly compared to those that do not?**

  Given that racial/ethnic groups provide different reports and ratings of care, should the data be risk adjusted so that plans that serve large numbers of racial/ethnic groups that report and rate their care lower are not penalized in the market?

Research on CAHPS Health Plan Survey data has yielded many important findings related to racial and ethnic disparities in consumer experiences with care. Future research on these and other CAHPS data will contribute to a greater understanding of health care disparities and how best to address them.

Products of the National CAHPS Benchmarking Database, *continued from page 7*

- **Research Files –** The CAHPS Database aggregates respondent-level data files across sponsors and health plans for the commercial, Medicaid, and SCHIP populations. Researchers may gain authorized access to data needed to help answer important health services research questions related to consumer assessments of quality. The data are available for researchers who submit an application and sign a data use agreement that ensures the confidentiality of the data. To date, more than 24 studies have been conducted using CAHPS Health Plan Survey data from the database; some of these results are described within this brief.

Sponsors, researchers, and others involved with the CAHPS Database also receive a quarterly electronic newsletter with updates and sponsor profiles, as well as opportunities to interact with other participants through User Group activities.

This research brief was published in November 2005 by the National CAHPS Benchmarking Database under AHRQ Contract Number 290-01-0003. The analysis and writing for the brief was conducted by Karen Onstad, who gratefully acknowledges the comments and suggestions of the authors of the studies cited in the brief and members of the CAHPS Database Advisory Group.